SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

A Life in the Community for Everyone

Recovery Community
Services Program
A PROGRAM OF THE SUBSTANCE ABUSE
AND MENTAL HEALTH SERVICES ADMINISTRATION'S
CENTER FOR SUBSTANCE ABUSE TREATMENT

Perspectives on the Evolution and Future of Peer Recovery Support Services

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DISCLAIMER

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PUBLIC DOMAIN NOTICE

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Executive Summary

> **"** …the stories of individuals in recovery attest to the challenges faced, the support received, and the steps taken to sustain recovery. These stories provide the essential building blocks for the development of peer services and help to overcome the stigma of addiction. **"**
>
> —RCSP Grantee, 2004

In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) recognized the growing influence of the mobilizing recovery community and the need to further a recovery–focused approach in addictions. SAMHSA initiated the Recovery Community Support Program to help in this effort by building an infrastructure for Recovery Community Organizations (RCOs) to support the expansion of peer-to-peer recovery support services (PRSS). In 2002, the program changed its name to the Recovery Community Services Program (RCSP). Since then, 74 RCSP grantees and their organizational partners have been at the forefront of supporting recovery community organizations and other agencies to develop peer recovery support services (PRSS).

SAMHSA is building on the legacy of the RCSP network and has actively taken several steps to help sustain and expand PRSS models, and the overall recovery community. In 2012, SAMHSA conducted a needs assessment with current and former RCSP grantees, as well as key stakeholder interviews with administrators and officials in the addictions recovery field, to document the successes and challenges of, and lessons learned about PRSS. The insights of RCSP grantees and stakeholders revealed in the needs assessment and interviews provided direction for a 2-day consultation meeting in September 2012. Topics discussed at this meeting by participants representing many intersections of the addictions recovery field are summarized below.

The Legacy of RCSP: Successes and Challenges. RCSP grantees credited the program with expanding peer recovery support and laying the groundwork for a national network of peer-run organizations with recovery values and peer voices at its center. Grantee achievements included mobilizing the recovery community, empowering underserved peers, building cross-system partnerships, developing quality standards and protocols for PRSS, and building peer-driven organizational and workforce infrastructure.

Among the challenges identified by interviewees were maintaining an authentic peer recovery role, gaining acceptance by clinicians, obtaining adequate funding and outcomes data, collaborating and integrating PRSS with other service systems, ensuring adequate peer leader training and supervision, maintaining advocacy support, determining the best locus for PRSS delivery, and developing links with other key organizations such as Federally Qualified Health Centers to expand delivery of PRSS. In addition, consultation participants emphasized the importance of a structural framework for PRSS that includes a strong foundation in recovery values and flexibility to respond to culture and community needs while establishing quality standards for service delivery.

Systems' and Funders' Perspectives on PRSS Financing and Delivery. Representatives of States and facilitating organizations (FOs) offered their perspectives on the planning and funding of RCOs and PRSS in interviews and during the consultation. For example, the Massachusetts Department of Health, Bureau of Substance Abuse Services recognized the importance of sustainability and building the business case for PRSS, and funded a network of peer recovery support centers by creating a map that identified funding and service gaps. In Georgia, the State developed and integrated PRSS within its delivery system by using a model from the mental health field that ensured Medicaid funding. Arizona's Community Bridges, Inc., an FO, employs 300 peer leaders in a variety of worksites, attracting funding from multiple sources. They view the coming changes in health care financing and delivery systems as a time of opportunity to increase support for PRSS and to invest in the infrastructure that will ensure quality peer services. Consultation participants agreed that PRSS are sustainable if a range of funding streams is accessed. Keys to success are data that support decision making, measures that showcase strengths, and stories that convey the power of services provided by peers. Continued participation by the recovery community is essential for service delivery and sustainability, as are training and technical assistance (TA) at the Federal level to ensure that the needs of the most marginalized groups of individuals (e.g., homeless; those with co-occurring disorders; people in reentry; lesbian, gay, bisexual, transgender, or questioning peers) are addressed.

Laying the Groundwork for PRSS Expansion in 2014 and Beyond. With the passage of the Patient Protection and Affordable Care Act (ACA), there is an increased focus on the role of community health workers (CHWs), and on the certification of peers and accreditation of organizations in the addictions field. Two identified trends are (1) the certification of peer specialists that can lead to improved reimbursement status under Medicaid, and (2) the importance of adequate training for peer supervisors. The CHW classification was cited as a model for a peer recovery workforce. At the same time, accreditation efforts that position RCOs and other recovery programs providing PRSS for sustained growth are being undertaken by the national addiction recovery organization Faces & Voices of Recovery. Consultation participants agreed that peer certification and organizational accreditation efforts in the addictions field are gaining momentum and will help support and sustain PRSS growth. Challenges include the need to identify funding sources for recovery community centers (RCC) and to ensure the delivery of authentic PRSS in a variety of service settings.

Participants of the consultation identified two major areas for TA needs and developed the following recommendations for future tools and TA to support the continued evolution of recovery-oriented programs and PRSS.

Communicating the Value and Contributions of PRSS	Sustaining PRSS in a Changing Health Care Environment
Tools 10 Benefits of PRSS Statement on PRSS Values Common PRSS Data Tool Treatment Improvement Protocols for PRSS **TA Needs** Data Collection and Marketing PRSS Research to Support Evidence-based Practices Basics of Evaluation Advocacy-Oriented Peer Networks	**Tools** Case Studies Cost-Benefit Data Sheet Medicaid Basics RCO/FO Readiness Tool Summary Information That Defines PRSS and RCOs **TA Needs** Inclusion of peer-led addiction recovery programs in SAMHSA TA Centers for Peer-Led Programs

A SAMHSA Exchange. During an informal exchange with consultation participants, senior SAMHSA leadership conveyed the agency's overall support for PRSS and acknowledged the achievements of the RCSP grantees. In addition, participants communicated the need for SAMHSA's technical assistance; flexibility in the use of Substance Abuse Prevention and Treatment Block Grant funds to support peer-led, recovery-oriented services; funding streams to sustain RCOs and RCCs; and expanded peer learning and career ladders for addiction peer recovery support specialists and peer recovery coaches.

Reflections on Moving Forward. As the health care environment changes with the implementation of the Mental Health Parity and Addiction Equity Act and the ACA, traditional notions of segregating substance use services from the rest of medical care will recede. Addictions will be addressed as a chronic disease, and the recovery community and the RCSP have prepared the way for PRSS to be a part of the expanded and integrated continuum of health services that emerges.

Section I: Introduction

In the United States, individuals struggling with substance use disorders number in the millions. Despite the benefits of various interventions and treatments, many people experience repeated cycles of deteriorating health, dysfunctional behaviors, and relapse. Today there is ample evidence that addiction is a treatable disease and recovery is an achievable reality. In fact, more than 20 million Americans identify themselves as in recovery from an addiction to alcohol or other drugs.

Expanded research, coupled with the experiential knowledge of those in recovery, has created an awareness that substance use disorders are chronic rather than acute conditions. As a result, recovering from such disorders is best understood as a process that responds effectively to treatment and psychosocial and cultural supports, particularly peer recovery support services (PRSS). As the term implies, these services are designed and delivered by people who have experienced both a substance use disorder and recovery. PRSS have proven effective in engaging people in clinical treatment, extending the effects of such treatment, and reaching well beyond treatment into individuals' everyday environments for the long term.

The term "recovery" has now taken its rightful place in our addictions lexicon. Recovery is an approach to addictions that includes treatment as just one part of a long-term process that involves support from within dynamic community settings. It is a growing influence not only in the US but internationally.

Since 1998, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Recovery Community Services Program (RCSP) has been at the forefront of supporting addictions recovery community organizations (RCO) and related PRSS. Its 74 grantees and their organizational partners have grappled with the challenges and rewards of creating quality program models for peer-based addictions recovery. As a result, these recovery leaders enjoy a unique vantage point from which to offer creative and specific strategies for strengthening systems and sustaining recovery.

Peer-to-Peer Recovery Services Core Values

Keeping recovery first – placing recovery at the center of the effort, grounding peer-to-peer services in the strengths and innate resiliency that recovery represents

Participatory process – involving the targeted recovery community in project design and implementation so that recovery community members identify their own strengths and needs and design and deliver peer services that address them

Authenticity of peers helping peers – drawing on the power of example, as well as the hope and motivation that one person in recovery can offer to another; providing opportunities to give back to the community; and embracing the notion that both people in a relationship based on mutuality can be helped and empowered in the process

Leadership development – building leadership among members of the recovery community so that they are able to guide and direct the service program and deliver support services to their peers

Cultural diversity and inclusion – developing a recovery community peer support services program that is inclusive of various groups and that honors differing routes to recovery, including medication-assisted recovery

As SAMHSA looks beyond the RCSP, it has launched a multipronged effort designed to capture the valuable lessons learned by the RCSP grantees. At the same time, it is actively pursuing approaches to help sustain and expand the reach and effectiveness of PRSS, RCOs, and the overall recovery community in the years ahead.

In mid-2012, SAMHSA initiated key stakeholder interviews to document the achievements of the RCSP grantees as well as the challenges that they face as health care financing and delivery systems pivot to address the Patient Protection and Affordable Care Act (ACA). The results of the 19 interviews, plus the responses to an online assessment of RCSP grantees' progress and needs, provided the direction for a 2-day consultation meeting in September 2012.

The purpose of the consultation was to assess the future of PRSS by discussing lessons learned and best practices related to PRSS and the organizations that provide those services, including how RCSP funding has helped organizations and programs evolve over the past 15 years. The outcomes from the consultation, including ideas and strategies for the future, are incorporated in this meeting summary.

Defining Key Recovery Concepts and Terms

Several key recovery concepts and terms were used repeatedly throughout the consultation. They provided a foundation and framework for the presentations and discussions that occurred during the meeting. These key concepts and terms are as follows:

> " The RSCP project improved the State's awareness of the integral part that recovery support services and peer support play in successful outcomes and creating long-term recovery. "
>
> —RCSP Grantee, 2004

Key Recovery Concepts and Terms

Recovery Community Organization (RCO)

An independent, nonprofit organization developing and delivering PRSS, governed and operated by members of the recovery community. These community-based organizations demonstrate ways to prevent relapse, promote long-term recovery, and improve the quality of life of individuals in and seeking recovery. RCOs may work closely with, but are independent of, other service organizations and act as bridges between recovery communities and a larger network of service providers and systems. RCOs frequently deliver PRSS at one or more recovery community centers (RCC).

Facilitating Organization (FO)

An organization that hosts a project to develop and deliver PRSS. An FO must ensure that members of the recovery community are involved in all aspects of program development and implementation. Some FOs are treatment programs, while others are organizations serving specific populations affected by addictions, such as people who are homeless, have HIV/AIDS, are reentering the community from a correctional environment, or are children at risk for neglect and abuse.

Recovery Community Center (RCC)

A recovery-oriented place in a community that exists to assist individuals with their recovery. RCCs are uniquely designed to meet the needs of their community members and typically are run by staff and volunteers. They offer recovery coaching and support groups, help to access related services like employment and housing, educational and social events to enhance recovery, and support for family members and friends. The centers put a public face on recovery and are places where a person in long-term recovery can "give back" by volunteering to work with others.

Peer Recovery Support Services (PRSS)

Social support services, designed and delivered by people who have experienced both a substance use disorder and recovery, to meet the needs of people in or seeking recovery. They include services that provide emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support. PRSS are delivered in multiple settings, ranging from RCCs, treatment programs, and criminal justice agencies to homeless centers, campus agencies, and faith-based organizations.

Recovery-Oriented System of Care (ROSC)

A coordinated, person-centered network of community-based services and supports that builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

The Consultation: Diverse Perspectives on PRSS Infrastructure and ACA Opportunities

The September consultation meeting included seven representatives of past and present RCSP grantees, three substance use administrators from two States and one city, one treatment provider, and one representative from the national advocacy organization Faces & Voices of Recovery (Faces & Voices). Participants met in Rockville, Maryland, and reviewed the results of the key stakeholder interviews and feedback on the impact of the RCSP, including successes and challenges. They explored strategies for strengthening PRSS in the future and engaged SAMHSA in a discussion of evolving roles, opportunities, and priorities.

This document presents highlights from the consultation and begins with the themes that emerged from the interviews with stakeholders, and from the online needs assessment completed by RCSP grantees. The chapter titled "The Legacy of the Recovery Community Services Program: Successes and Challenges Delivering Peer-Driven Services" focuses on peer-driven services that were developed by establishing and growing the network of RCSP grantees. Additional topics covered by the interviews included important partnerships, ACA-related issues, and needed technical assistance (TA) and tools. The chapter concludes with participant comments on the interview and needs assessment themes.

The next chapter, "Exploring Systems' and Funders' Perspectives on PRSS Financing and Delivery," presents the experiences and perspectives of two States and a facilitating organization regarding PRSS. It includes participant comments on the key points that were raised.

The chapter titled "Laying the Groundwork for PRSS Expansion in 2014 and Beyond" summarizes elements considered critical for the future of PRSS as we enter a new era of health care, and it includes the contributions of two consultation participant workgroups. These workgroups focused on (1) the contributions and value of PRSS for addictions recovery and (2) PRSS in a changing health care environment. Participants of each workgroup provided specific recommendations for TA and tools to advance the evolution of PRSS.

The chapter titled "A SAMHSA Exchange" includes highlights of a discussion between participants and SAMHSA senior leadership. The discussion centered on the demonstrated value of RCOs and PRSS, potential Federal opportunities to provide continuing support beyond the RCSP, and implications of a changing perspective regarding recovery within the national health care environment.

The final chapter, "Reflections on Moving Forward," presents concluding thoughts, an optimistic perspective for PRSS in light of the progress that has been made, and a vision for ROSCs under the ACA.

Appendices to this report include the consultation meeting agenda and the list of meeting participants.

Section II: The Legacy of the RCSP—Successes and Challenges From More Than a Decade of Peer-Driven Services

Overview

Information from interviews with RCSP stakeholders, as well as feedback on the impact of RCSP from current and former grantees, was presented at the start of the consultation to provide background and context for the work.

Methodology

Rich information and perspectives for SAMHSA and the consultation participants came from two sources. One was an online, self-administered TA needs assessment completed by 27 current and former RCSP grantees. The assessment posed questions about the impact of their RCSP projects on the recovery community and service systems and what they needed to sustain and expand PRSS. For the second source, SAMHSA conducted 19 telephone interviews with RCO, FO, State, and city substance use administrators from 12 jurisdictions. The semi-structured protocol explored stakeholders' experiences with PRSS programs, including lessons learned and best-practice models for PRSS and the organizations that provide them.

The administrators interviewed confirmed the importance of SAMHSA's RCSP in mobilizing recovery communities and providing PRSS. Current and former RCSP grantees concurred in their feedback and described the program's

legacy of empowering underserved peers, building cross-system partnerships, and developing peer-driven organizations and the peer workforce.

The administrators interviewed confirmed the importance of SAMHSA's RCSP in mobilizing recovery communities and providing PRSS. Current and former RCSP grantees concurred in

The Impact of RCSP: Key Themes From a TA Needs Assessment

In the TA needs assessment, RCSP grantees credited the program with laying the groundwork for a national network of peer-run organizations and addictions services, with recovery values and peer voices at its center.

Through the interviews and TA needs assessment with current and past RCSP grantees, a number of key themes emerged on the impact of the RCSP. These core RCSP activities translated into meaningful changes in addictions recovery and treatment systems at the local, State, and national levels.

Beginning on the next page are the key themes that were identified: 1) Increased focus on underserved peers; 2) Impact of PRSS on policies and communities; 3) Impact on organizational and workforce development; and 4) Impact on systems change.

> " We helped mainstream the concept of recovery support services in our State. "
>
> —RCSP grantee, 2007

Increased Focus on Underserved Peers

RCSP grantees provided PRSS that made recovery possible and sustainable for thousands of peers, including:

- Adjudicated adolescents in recovery from substance abuse and co-occurring disorders;
- Homeless Veterans;
- Medication-assisted individuals;
- Latinas and African-American women living with or at risk for HIV/AIDS;
- Men and women coming out of the criminal justice system seeking recovery;
- Individuals with chronic health conditions;
- Isolated rural populations;
- Adults and youth leaving treatment and new to recovery;
- Native American youth and adults;
- Peers in halfway houses, sober houses, and transitional living facilities;
- Peers seeking health services in emergency facilities and Federally Qualified Health Centers (FQHCs); and
- Lesbian, gay, bisexual, transgendered, or questioning (LGBTQ)-identified peers.

Impact of PRSS on Policies and Communities

- Mobilized the recovery community to affect systems and policies.
- Promoted many paths to recovery.
- Established a venue for peers to get support and voice their concerns about reentering the community.
- Provided essential support before, during, and long after treatment that helps peers take full responsibility for their recovery.
- Shared empowering peer stories and fight stigma.
- Reached families and allies.
- Promoted social interaction among peers, a key part of recovery maintenance.
- Showed value of adolescent peer support in sustaining sobriety.
- Established concept of medication-assisted recovery.
- Helped women make the connection between trauma experiences and substance abuse.
- Built a network of recovery support and services for former offenders.

> " The women who were once residents of this [Women's Detention Facility] now return to serve and support others in their reentry journey. These women become powerful role models for those who are still incarcerated, and are a testimony to what is possible. "
>
> —RCSP grantee, 2004

Impact on Organizational and Workforce Development

- Developed recovery coaching models and trainings and generate revenue.
- Established a network of effective peer-run services.
- Trained and empower peer leaders.
- Filled gaps in the traditional services continuum.
- Created a cost-benefit analysis from training and supporting a volunteer workforce.
- Enabled and enhance cross-system partnerships.

Impact on Systems Change

- Established State certifications for Peer Recovery Support Specialists.
- RCSPs became PRSS providers for managed care organizations.
- Influenced States, health, housing, employment, and correctional systems, and turn those partnerships into new funding.
- Developed statewide resource and community support networks.

> " Los Angeles is replete with agencies willing to offer their services…to reduce crime and improve rehabilitation efforts. Our [RCSP] project brought these agencies together under the name of "Life Corps," which gave us the…opportunity to provide holistic services beyond what the CSAT budget allowed. "
>
> —RCSP grantee, 2004

> " PRSS are starting to have an influence on medication assisted treatment facilities [that] come to [us] for information and training to make [opioid treatment programs] more recovery oriented. "
>
> —RCSP grantee, 2010

Successes and Challenges With PRSS: Interviews With Stakeholders in Addictions Recovery

Single State Authorities (SSA), RCO directors, and program administrators discussed the impact of peer-led recovery services on their systems and communities and lessons learned for PRSS development and implementation in a round of interviews. They painted a picture of a strong network of PRSS programs that sustain recovery and operate in multiple service settings, but they pointed out challenges in producing PRSS outcomes data and responding to integration needs under the ACA.

Key Stakeholder Interviews: Successes of PRSS

- **PRSS are effective along the entire trajectory of the recovery experience,** from recovery initiation to maintenance, and are effective whether delivered pre-treatment, contemporaneously with treatment, post-treatment, or independently of treatment.

- **PRSS adhere to recovery and peer principles and values,** including retaining the authenticity of the peer relationship, healing through community, maintaining a participatory process and future orientation, focusing on strength-based approaches, and valuing the experiential wisdom of peers.

- **PRSS reach underserved and/or stigmatized groups,** such as ex-offenders or people who are disabled or homeless, have mental health conditions, are active users, or are walking a medication assisted path of recovery.

- **PRSS are successfully implemented in a wide variety of service settings,** such as substance use treatment programs, transitional and permanent housing, HIV/AIDS programs, criminal justice systems, primary health care practices, and FQHCs.

- **Effective workforce infrastructure** supports peer leaders and includes role definitions, an ethical framework for service delivery, training, supervision, self-care guidelines, human resource policies and procedures, and benefits packages.

- **Organizational infrastructure** that supports PRSS includes risk management, fiscal management, and governance policies and procedures.

- **Linkages and partnerships strengthen the reach and effectiveness of PRSS** through robust and accessible webs of community-based recovery supports. These supports include substance use treatment, safe housing, mental health services, HIV/AIDS testing and treatment, medical and dental care, education and vocational training, recreational opportunities, employment, reentry assistance, communities of faith, and opportunities to give back.

- **Ongoing community mobilization and peer leadership development** are instrumental in strengthening the authentic recovery voice, raising the profile of recovery, and carrying the recovery message of hope to the community at large.

- **Pressures to move toward a more clinical treatment model** and adopt the language of behavioral health and the ACA raise concerns about the capacity to stay true to an authentic peer recovery model. Under the clinical model, peer leaders risk being viewed as "junior counselors" or "counselors light" and losing the authenticity of PRSS.

- **Misunderstandings and biases about PRSS** include treatment networks that are closed to PRSS and a lack of acceptance by clinicians of nonclinical approaches to care.

- **Declining funds for PRSS infrastrucure.** As RCSP and other funding contract, there is less funding for RCOs and FOs to support basic infrastructure and evaluation needs.

- **Maintaining the recovery focus and bridging differences across recovery communities and other service systems** with respect to language, culture, procedures, roles, and stigma is difficult. There is reluctance by some host organizations to permit full peer participation in program design and decisionmaking. Other challenges concern the training of peer leaders, peer leader turnover, adequate supervisory training, and supervision of peer leaders by clinicians as required under Medicaid, who have the potential to dilute the "peerness" of PRSS.

- **PRSS and RCOs continue to need advocacy support at all levels**, particularly efforts by national recovery support organizations similar to those that operate effectively in the mental health field.

- **Research and outcomes data are inadequate** to assess which service settings might be best for PRSS delivery.

- **Developing links with FQHCs, managed care, and commercial payers** to expand delivery of PRSS is a new challenge under the ACA. Providers of PRSS need to prepare for these opportunities and enhance their capacity to negotiate and optimize such partnerships.

Discussion

Participants at the consultation agreed with the main themes listed above that emerged from the key stakeholder interviews and the RCSP grantee feedback. In addition, these points surfaced during the discussion:

Promote and advocate for PRSS in addictions. Participants noted that PRSS in addictions are still in the early developmental stages despite substantial progress. PRSS and recovery values are not yet widely included in addictions training curricula. The principles and values of recovery and recovery communities are not well-known or -accepted within other service systems (e.g., housing, criminal justice, State substance use organizations, Medicaid agencies, managed care groups, primary health care) or among the research community. It is especially important to continue to advocate for and educate others so that they understand and become comfortable with recovery concepts, PRSS, and the curative nature of recovery.

Be sure to engage the recovery community. Participants emphasized that the recovery community must be engaged in planning for and implementing PRSS and at the forefront of creating ROSCs. Doing so will help ensure that PRSS remain authentic, peer leaders receive critical support in their new work

environments and that key relationships and partnerships with other service systems are created based on a clear understanding of core recovery principles and values.
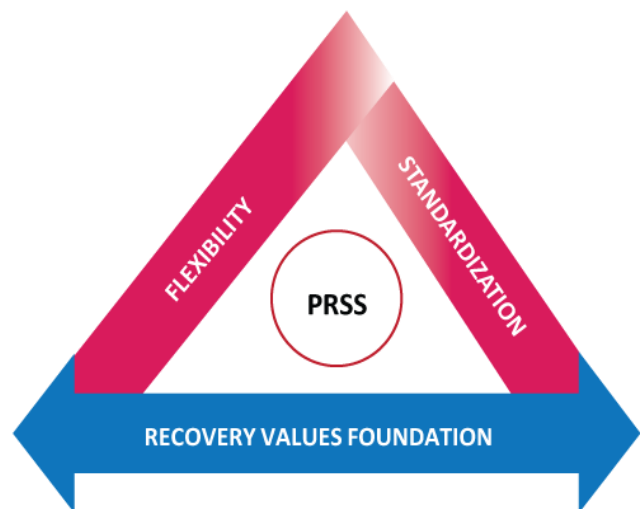
Increase standardization. The developmental stage of PRSS is reflected in still evolving definitions and incomplete standards for measuring their quality, cost, and other dimensions of service delivery. Recognizing that multiple dimensions for these services are under development, participants emphasized the importance of and need for standardized, validated impact measures and costs for PRSS that document effectiveness and can help secure funding. Standard descriptions that define PRSS are essential to "brand" these services at a national level, along with training and constant monitoring to ensure that quality standards are maintained. One State's experience provides an example of the importance of standardization. They received Medicaid funds for PRSS but, in the absence of clear service definitions, found that providers used the PRSS billing codes without fulfilling the service requirements.

Honor recovery values and remain flexible while establishing standards. In counterbalance to the momentum behind standardizing definitions, processes, training, and measures is the importance of maintaining flexibility. Participants recognized the importance of maintaining the values of PRSS, which emphasize empowering and supporting individuals and communities with widely varying expectations, resources, and culture, to make decisions regarding their unique path to recovery. Equally important was the recognition that the recovery community has been instrumental in highlighting the many

legitimate paths to recovery, including medication-assisted recovery.

The graphic that follows depicts a key idea that arose during the group discussion. It reflects agreement about the importance of having a strong foundation in recovery values to help center the tensions of maintaining flexibility and establishing the needed standardization for systems. Participants shared that balancing these tensions is how PRSS will evolve in the future; falling short on any part of these concepts could result in challenges for a program providing PRSS. This structural framework supports the goals of participation and individual decisionmaking, flexibility in designing programs and delivering authentic services, and setting high quality standards that maximize effectiveness and minimize fraud and abuse.

Figure 1. A Structural Framework for PRSS

Section III: Exploring Systems' and Funders' Perspectives on PRSS Financing and Delivery

Overview

States and FOs are essential participants in the planning and funding of RCOs and PRSS. Representing State perspectives were Michael Botticelli, former director, Massachusetts Bureau of Substance Abuse Services; and Cassandra Price, executive director, Division of Addictive Diseases in the Georgia Department of Behavioral Health and Developmental Disabilities. John Hogeboom, vice president and chief operating officer of Community Bridges, Inc. (CBI) in Arizona, represented the facilitating organization perspective. Highlights from their presentations follow.

Massachusetts

The Massachusetts Department of Health's Bureau of Substance Abuse Services has funded a network for peer recovery support centers located throughout the State. These projects are operated under the organizational umbrella of a variety of health and service groups and are peer-driven, community-based centers. The centers are welcoming places for individuals and families who have been negatively affected by addictions. They receive support through educational, social, skill-building, and volunteer activities.

The State created a financial map to identify funding gaps and develop priorities. This map identified the sources of funding for various addiction services such as prevention, intervention, treatment, and recovery. The mapping revealed that the vast bulk of available funding in the State supported acute treatment services. Through this process, the State developed strategic funding priorities for a broader continuum of care, including recovery support services. This process is instructive in that it can demonstrate significant gaps in funding.

Sustainability is an important consideration at the State level. Federal grants sometimes fund services that are unsustainable when the grants end. To address this issue, recipients of Federal PRSS grants should develop relationships with the State's SSA early on, well before funding ceases. One important strategy is to invite State staff for site visits to learn firsthand about program operations and staff competency. Other useful strategies include tapping available State resources for TA and providing the State with data on outcomes and the impact of PRSS.

Building the business case for PRSS is critical to justify continued funding. Individual-level data can be used to demonstrate that peers who received PRSS did not return to hospital emergency rooms, detoxification units, or the criminal justice system. Such data are essential to make the business case for PRSS. For example, the State needed to justify the $2 million allocation of funds for recovery support services. Data that showed outcomes and impact, such as lower recidivism rates and better family restoration outcomes, were part of making a successful health economics business case that PRSS warranted the allocation of taxpayer dollars.

There is an opportunity to reevaluate funding available from the SSA. Under the ACA, there is now a significant opportunity to reevaluate how funding that is available to the SSA can be redeployed to support RCOs and PRSS. The ACA's implementation will open up avenues of reimbursement for a continuum of substance use services and may mean current funding can be redeployed to provide additional services that strengthen recovery in communities.

Georgia

Georgia has a long history of implementing community- and peer-based programs and support services for its citizens with mental health conditions and their families. More recently, the State has worked with those in addictions recovery to leverage this mental health experience, creating and funding PRSS for addictions, including a certified training program for addiction peer recovery coaches (the CARES program). These recovery coaches provide recovery planning and resource utilization, individual and group recovery support, and recovery advocacy services.

The State developed and integrated PRSS on a small scale within its delivery system. Georgia is a State with a limited budget for substance use services. With careful financial planning, PRSS were funded from cost savings that were gleaned from throughout the service system. The subsequent CARES program (certified addiction recovery empowerment specialist) was modeled on the mental health peer support program already in place, but tailored to addictions recovery. This effort paved the way for productive collaborations with the mental health system and with the Medicaid agency.

The PRSS model incorporated all elements that ensured reimbursement under Medicaid. Key elements of the model included coding, service definitions, and certification. The model targeted an existing workforce and provided peer leaders with credentials and support as well as training for their supervisors.

Qualitative stories of PRSS successes were helpful but not sufficient. Success in securing funding for PRSS required qualitative and quantitative data. Qualitative stories of PRSS effectiveness must be accompanied by cost analyses that demonstrate how the State system is saving money or outcomes are changing.

Community Bridges, Inc.

Community Bridges, Inc. (CBI) is a substance use treatment and mental health provider with facilities throughout the State. Its peer program has grown to offer PRSS by more than 300 peer leaders. These leaders work in a variety of sites, including in inpatient detoxification and outpatient settings, mobile and shelter-based services, and behavioral health crisis stabilization centers; on Tribal lands; and at police and fire stations, FQHCs, and homeless shelters.

A variety of funding resources were used to pay for PRSS. CBI has been successful in aggressively attracting funding for its peer-led program from multiple sources, including Substance Abuse Prevention and Treatment Block Grant (Block Grant) and Medicaid funding streams. In addition, insurers (e.g., managed care) now pay for PRSS, since they see evidence of positive outcomes. In other instances, cities within Maricopa County have

continued to support PRSS as a result of the advocacy efforts by communities that recognized their value. Tribal governments, such as the Navajo Nation, started funding culturally specific PRSS once they saw demonstrations of culturally specific services and effectiveness data. Peers are now collocated strategically throughout the State, working in tandem with police and fire departments to reduce emergency department admissions, as well as the number of first-responder emergency services required such as ambulances.

This is a time of opportunity for peer services. Changes in health care present a great opportunity for PRSS providers to innovate and move with the times. For instance, it is clear that Medicaid is going to be reimbursing for preventative and related wellness services. In recognition of this change, CBI is now reimbursing its peer leaders for taking certification courses in various wellness specialties (e.g., nutrition) through a company-wide tuition reimbursement program.

Sustain PRSS funding by viewing every funder as an investor. A successful strategy for sustaining PRSS funding is to view funders as "investors" and then show investors that services are positively affecting their budgets and helping them achieve their missions.

Invest in infrastructure for PRSS providers. A provider of PRSS needs a strong and supportive organization that truly "gets" the value of peer services and provides an infrastructure with the necessary administrative and other critical structural processes and systems.

Discussion

The discussion focused on the future of PRSS, including achieving sustainability and making the business case for the viability of the services. These points were made:

PRSS are sustainable. Participants provided examples of PRSS that are being sustained. For instance, Medicaid funding is being reduced in multiple States, but PRSS services funded by several investors are not being cut back. Investors, such as health insurers, continued to pay for these services when data from hospitals showed reduced costs and better outcomes. One large metropolitan city has contracts with departments such as mental health and with the local jails. When these organizations saw data showing that individuals were not rearrested or returning for care or services, they were willing to keep funding PRSS. Another State just passed legislation to create a fund to finance recovery support services through a grant program. While funding mechanisms may be changing and somewhat complicated, different funding streams are available. RCOs and FOs can successfully access these funding streams with the necessary tools, knowledge, and assistance.

Establish realistic baseline measures on service effectiveness with investors. There are multiple approaches and different algorithms that can be used to create realistic baseline effectiveness measures. For example, it was suggested that RCOs and PRSS programs might ask, "What does success look like for you?" or "What measures do investors want used?" Another suggestion was for programs to decide what they can provide and then identify who can pay for it. Some States use performance-based contracts to control for improvement. Ultimately, it is critical to understand that programs must be accountable.

A robust data set is essential for PRSS decisionmaking and funding. This dataset should extend beyond existing Government Performance and Results Act (GPRA) measures to include Medicaid, hospital, and criminal justice data that showcase PRSS strengths. The data must be useful to States and other health care participants interested in providing PRSS under the ACA. Even though States have found GPRA data to be useful, additional data must now support decisionmaking and funding if PRSS programming is to meet the changing requirements of investors under the ACA.

Sustainability is about more than data and justifying the value of RCOs and PRSS. It is also about recovery voices and people in places of power. It was suggested that the recovery community needs to mobilize to be at the table and in the right places. "When we had a city council person in recovery, there was much more interest in PRSS by the city."

Provide continued Federal support for PRSS for marginalized population groups. If recovery is to flourish, communities must emphasize the needs of the most marginalized groups (e.g., homeless, co-occurring, reentry, medication-assisted, and LGBTQ populations). Even though States may provide PRSS, not every individual will have access to them and not all communities will have the same recovery needs or approaches. Training and TA from the Federal level will be important in positioning and enhancing access to PRSS under health care reform.

The State of Georgia has an established relationship with the Centers for Medicare & Medicaid Services (CMS) for reimbursing mental health peer specialists. That precedent is helping Georgia advance the approval process for substance abuse peer specialists.

Section IV: Laying the Groundwork for PRSS Expansion in 2014 and Beyond

Overview

The environment in which PRSS are funded and delivered is rapidly evolving to address the requirements of the ACA. The table below highlights some of the considerations for PRSS in this changing landscape. Two key elements closely associated with the ACA are the definition of peer roles and opportunities and the accreditation of organizations delivering PRSS. Highlights of presentations covering the roles of community health workers (CHW) and accreditation are presented in this section.

These presentations set the stage for two small workgroup discussions. Each group developed recommendations for how to prepare and connect PRSS with health care delivery going forward.

Considerations for PRSS in the Evolving Health Care Landscape

Positioning for funding: Medicaid, Block Grant, managed care, private payers

Funders and States requiring a level **of quality assurance and accountability** for services delivered

Many States moving toward **certification** of recovery coaches, navigators, and peer recovery support specialists

State trends for merging mental health and substance use disorder systems and services

Delivery of PRSS in diverse offsite service settings

Source: Faces & Voices of Recovery
http://www.facesandvoicesofrecovery.org

Peer Roles and Opportunities Under ACA

States are developing certification programs for addiction peer recovery support specialists. While certification of mental health peer specialists is well-established, certification of addiction peer recovery support specialists is now occurring in some States. This trend in the certification of addiction peer specialists can lead to an improved reimbursement status when services are delivered through organizations with established Medicaid billing systems.

Supervision for addiction peer recovery support specialists is needed. Peers who support the recovery efforts of others are also continually working on their own recovery. A critical element for the long-term effectiveness of PRSS and peer specialists is the quality and nature of the supervision that they receive as they assume their roles and responsibilities. Some of the key elements of supervisory support for peer specialists include assistance in coping with trauma, preventing relapse, and creating and maintaining effective self-care.

Follow the CHW example. The recent trajectory of CHWs presents a possible model for recovery coaches, peer recovery support specialists, and other peer providers. In 2009, the U.S. Department of Labor recommended the creation of a Standard Occupational Classification for CHWs, and in 2010 the classification was formally created. CHWs were then named in the ACA legislation, paving the way for their integration into primary health care teams. The CHW occupational classification and inclusion in the ACA were supported by large data studies showing a

positive CHW impact on health care access and outcomes for people with chronic health conditions and in underserved communities. As CHWs have gained recognition, they have also formed some strong State associations to organize and advocate for their seat at the planning table. The CHW example suggests that more data on PRSS outcomes could be a starting point for legislative recognition to sustain the peer recovery workforce. Membership organizations like CHW associations might also empower peer providers.

CHWs, Peer Recovery Support Specialists, and Health Care Reform

CHWs

- "In 2009, the U.S. Department of Labor recommended the creation of a Standard Occupational Classification for community health workers"

- Named in Prevention and Public Health Fund legislation

- State associations leading the way in Massachusetts and Minnesota

Peer Recovery Support Specialists

- Some States use the blanket term "peer recovery support specialist" to designate an individual who delivers mental health PRSS or addiction PRSS

- States may use a variety of other terms to designate an individual who delivers addiction PRSS, such as "recovery coach" or "recovery navigator"

Accreditation

Accreditation in the current health care environment is critical. Accreditation efforts are occurring within a health care environment that emphasizes low-cost, effective services and outcomes; ACA and Mental Health Parity and Addiction Equity Act (Parity) legislation; the development of ROSC to address addiction as a

chronic health condition; the integration of substance use, mental health, and primary health care services; and the emergence of peer and other recovery support services.

Position RCOs and PRSS for funding. Organizational accreditation is an increasingly critical component for funding and requires meeting quality assurance and accountability requirements. Accreditation assists RCOs and other PRSS programs to build competency and infrastructure by requiring the development of high standards and implementation of best- and evidence-based practices.

A national peer recovery support accreditation initiative is under way. Faces & Voices of Recovery, the nationally recognized voice of the organized addictions recovery community, is developing an accreditation system for organizations providing PRSS. The system is expected to be up and running for the implementation of the ACA in 2014.

RCO Accreditation Framework

Four Functional Areas:	Within Each Area:
Principles People Practices Performance	Core Domains Standards Indicators

Source: Faces & Voices of Recovery
http://www.facesandvoicesofrecovery.org

Faces & Voices views accreditation of organizations providing PRSS not as an alternative to certifying individual practitioners but as an important complement to it.

Discussion

The discussion focused on the implications of accreditation and certification for PRSS and the

challenges of providing peer services within the broader health care environment. The following points were made:

Ensure that addiction peer recovery support specialists join CHWs at the health care table and are involved in chronic disease management. The competencies and roles of CHWs and addiction peer recovery support specialists are complementary, and both are needed to improve access to and enhance the health and recovery of individuals with substance use disorders. As health care systems are revised under the ACA, providers of and advocates for PRSS must be more effectively connected with decisionmakers at the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, CMS, and other agencies. *As a case in point, one State participant reflected that there are ongoing discussions about CHWs and certification of mental health peers but not about peer recovery support specialists for addictions. The ACA is an opportunity to mobilize and secure additional funding streams for PRSS and other recovery support services.*

A more robust recovery research agenda is needed. An enhanced recovery research agenda will provide data to determine promising and effective practices and to document the value of PRSS. Participants suggested that areas for specific research include cost savings in emergency departments and treatment services, building social support, family strengthening, care coordination, and recovery awareness.

Accreditation offers benefits for PRSS. Participants acknowledged the significant challenges of delivering relationship-focused, peer-based recovery services in health care environments that value enhanced productivity and a hierarchical culture. The accreditation model being developed by Faces and Voicesaims at producing benefits that include improved service quality and accountability, enhanced billing for services, and expanded opportunities to participate on multidisciplinary health care teams. Furthermore, the Faces and Voices accreditation model includes standards for peer self-care and supervisory support for peers that have proven essential for effective service delivery.

Peer certification programs in the mental health field are already in place, and interest in the certification of peers in the addictions field is now gaining momentum. The International Certification and Reciprocity Consortium presently offers two levels of professional certification. However, these certifications reflect a clinical rather than a peer-based model. There were also concerns about (1) maintaining the integrity and authenticity of PRSS in existing clinical and treatment organizations so that peers do not become "junior counselors" and (2) the potential administrative burden of responding to multiple certification programs for various peer positions.

States are in different stages of development regarding the PRSS workforce, recovery communities, and RCOs. Fundamental challenges concern the interplay of clinical services, PRSS, and RCOs so that they become complementary and mutually supportive rather than competitive or duplicative delivery systems. Ultimately, participants emphasized that everyone has the same goals: improved health and well-being and recovery from addictions.

Medicaid has approved reimbursement for peer coaches and peer navigators in various States but does not fund RCCs. Peer coaches and peer navigators are recognized as qualified to deliver PRSS and are increasingly becoming eligible for Medicaid reimbursement. However, settings such as RCCs in which PRSS are delivered and recovery is supported are not yet approved for Medicaid reimbursement. Blended funding is needed to sustain these valuable organizational supports and the recovery environments that they nurture.

There are challenges to the delivery of authentic PRSS in various service settings. Efforts to embed PRSS within organizations other than RCOs, such as substance use treatment programs or primary care clinics, have been successful, but obstacles have surfaced as well. For example, peer leaders have not always been equal participants in conversations and decisions about the types and methods of service delivery. In some cases, PRSS have been subsumed within a clinical and medical service delivery model. In other instances, programs have not always faithfully adhered to the core principles and values of recovery, such as honoring differing routes to recovery, building peer leadership, providing opportunities to give back to the community, involving the recovery community, and placing recovery at the center of all efforts.

A Workgroup on the Contributions and Value of PRSS for Addictions— Recommendations for TA and Tools

Workgroup members focused on the power and uniqueness of PRSS and the value of community mobilization. With this foundation, it was acknowledged that PRSS providers and recovery communities must be prepared to "make the case" to multiple audiences, with data and personal stories, for the benefits and impact of PRSS. Increasingly, PRSS will be delivered in many different settings and these settings and services must reflect recovery values. Participants also emphasized that the recovery learning community established under the RCSP has been especially valuable in supporting the development of important recovery messages and expertise in community building and service delivery.

The workgroup recommended the development of these TA strategies and tools:

Communicating the Value and Contributions of PRSS—TA and Tools
10 Reasons to Support PRSS. A list of the top 10 reasons to support PRSS, such as reduced stigma, relapse, emergency department visits, and crime; improved employment, housing, and family life; and reduced costs.
PRSS Values. A list of the values that support PRSS.
Common Data Tool. A common national data collection form to capture information on PRSS costs and benefits.
Data Collection and Marketing. Tools that support PRSS data collection and on how to use data in branding and marketing PRSS to various audiences (e.g., managed care organizations, primary care practices, hospitals, funders).
PRSS Research. Research on topics such as cost savings, care coordination, peer engagement, building social support and recovery capital, and strengthening families.
Basics of Evaluation. Information on how to use State and Federal data resources to evaluate RCO and PRSS performance, how to partner with other organizations to collect data, and how to present data to different audiences.
Advocacy-Oriented Peer Networks. TA to support the development of statewide RCO and PRSS advocacy organizations.
TIPS for PRSS. A TA series on PRSS core competencies.

A Workgroup on PRSS in a Changing Health Care Environment— Recommendations for TA and Tools

Workgroup members discussed the likely effects of implementing the ACA, expanding Medicaid, and allocating Block Grant funds on PRSS and the peer recovery workforce. They identified components of the ACA that are relevant to PRSS, including Accountable Care Organizations (ACO), medical homes, linking and co-location with FQHCs, and CHWs. Key audiences for PRSS under the ACA are hospitals, primary care physicians, FQHCs, employee assistance programs (EAP), family medical practices, and patient-centered medical home models. Workgroup members discussed the importance of acquiring data to document the value of PRSS, creating the persuasive "elevator speech," and describing the real costs to the community of not supporting recovery. In recognition of the expected expansion of Medicaid, the group saw the need to develop relationships with State Medicaid agencies and to develop the core competencies of PRSS providers to meet administrative requirements of Medicaid and other financing options. As States consider their allocation of Block Grant funds, input from the recovery community can help influence decisions to support PRSS, particularly for populations that remain vulnerable. Finally, the group identified the value of creating case studies of effective RCOs and PRSS programs that have worked with Medicaid, FQHCs, EAPs, and primary health care organizations.

The workgroup recommended the development of these TA strategies and tools:

Sustaining PRSS in a Changing Health Care Environment— TA and Tools

Case Studies – case studies that focus on addressing various aspects of the ACA using information from current demonstration projects, modified for target audiences such as RCOs, FOs, State agency staff, primary care physicians, medical associations, managed care organizations, hospitals, ACOs, FQHCs, and elected officials

Cost-Benefit Data Sheet – a 1-page data sheet that makes the business case for RCOs and PRSS

Medicaid Basics – talking points for working with a State Medicaid agency

RCO/FO Readiness Tool – steps and decisions required to set up and maintain RCOs and deliver PRSS under the ACA, including a cost-benefit analysis, pitfalls around maintaining the authenticity of peer services, CMS audits, accreditation and certification standards, codes, and billing

Technical Assistance Center – a TA center that assists SSAs, RCOs, and FOs with PRSS in the context of the ACA transition, Medicaid expansion, and Block Grant changes

Summary information that defines PRSS and RCOs – two separate fact sheets that present definitions and information on effective settings; discuss roles; and provide information on the development, monitoring, and evaluation of PRSS and RCOs

Section V: A SAMHSA Exchange

Overview

During an informal exchange with participants, senior SAMHSA leadership communicated the agency's overall support for PRSS and acknowledged the achievements of the RCSP grantees. In addition, these issues were discussed:

The role of the Block Grant in supporting the recovery community. Participants identified the need for TA for States that do not expand their Medicaid coverage under the ACA, potentially leaving segments of their population uninsured and without access to recovery services. Flexibility in the use of Block Grant funds can offer States opportunities to support recovery-oriented services. There were also concerns about maintaining the authenticity of PRSS under Medicaid regulations, and a recommendation that members of the recovery community be included on State-level behavioral health advisory boards.

The role of RCOs. Participants reiterated the value of RCOs and RCCs and identified the need for sustaining funding streams for these organizations. Furthermore, participants suggested that expanded efforts are needed to build statewide advocacy networks that can generate additional support for RCOs, PRSS, and the entire continuum of care.

Peer learning and pipeline development. There was consensus on the need to develop career ladders for addiction peer recovery support specialists and to support continued learning opportunities that maintain the quality and authenticity of service delivery. It was noted that SAMHSA offers TA to help community-based organizations develop their business systems. The agency will explore convening a peer recovery support training cohort.

Section VI: Reflections on Moving Forward

Over the 2 days of consultation, participants acknowledged RCSP's many successes. There was a clear consensus that RCOs and PRSS have contributed to improved community life and individuals' recovery and overall well-being. These contributions have included reduced levels of stigma, relapse, emergency department visits, crime, and costs while leading to improved employment, housing, and family life. Participants also emphasized the particular value that they derived from the learning community of grantees that SAMHSA developed and nurtured throughout the duration of the grant program that still endures today.

Peer Recovery Support – It Works!

The Consultation produced examples and data from peer programs around the country that SAMHSA used to create a graphic on the **Benefits of PRSS** for communities and systems. (see Appendix A)

Participants mined the lessons learned as a result of RCSP. For example, there was agreement that recovery communities and stakeholders must develop ongoing funding sources for RCOs and PRSS. In addition, recovery communities must continue to build the necessary infrastructure and competencies to participate in a modified health care environment under the ACA, expand and strengthen the peer recovery workforce, develop the capacity to document the value and effectiveness of RCOs and PRSS, and continue effective advocacy for recovery initiatives.

Envisioning Recovery-Oriented Systems of Care After ACA

Medicaid reimbursement for PRSS

Block Grant funding for a range of recovery and peer-led support services

Strong partnerships with primary care practitioners and FQHCs

A peer workforce that builds bridges between various service systems

Continued development by RCOs of community- and relationship-building service constructs and advocacy around recovery

Improved access to sustained recovery in every community

The prepared presentations and lively discussions among participants resulted in recommendations of follow-up TA strategies and tools for SAMHSA's consideration. The strategies and tools were suggested by these key stakeholders in support of a new vision for recovery oriented systems of care following implementation of the ACA (see textbox).

Participants' expressions of pride in and excitement about the emergence of PRSS have implications for a continuum of care that integrates primary and behavioral health. With the implementation of Parity and ACA laws, traditional notions of substance use disorder services must change. The practice of segregating substance use disorder services from the rest of health care will recede as addiction is addressed as a chronic disease similar to HIV/AIDS, diabetes, and hepatitis C. Peer recovery support services are poised to be part of the expanded and integrated continuum of health services that becomes available.

The recovery community and RCSP have prepared the way for this change in the addictions field and substance use services. They have advanced our knowledge of recovery concepts, values, principles, and services, expanding the vision and reality of recovery that will be critical to performance by all players in the addictions and general health care fields in the era of health care reform.

By providing clarity about what constitutes recovery to include all aspects of a person's health and well-being, the recovery community represents a "breath of fresh air" for the addictions field and gives new dimension to the goal of integrated care that is well-coordinated, efficient, and designed to support each person's health regardless of circumstances.

To be effective, recovery-oriented systems must infuse the language, culture, and spirit of recovery throughout their systems of care.

—The Role of Recovery Support Services in Recovery-Oriented Systems of Care, SAMHSA 2008

http://store.samhsa.gov/product/The-Role-of-Recovery-Support-Services-in-Recovery-Oriented-Systems-of-Care/SMA08-4315

List of Acronyms

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
EAP	Employee Assistance Program
FO	Facilitating Organization
FQHC	Federally Qualified Health Center
GPRA	Government Performance and Results Act
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICRC	International Certification and Reciprocity Consortium
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
PRSS	Peer Recovery Support Services
RCC	Recovery Community Center
RCO	Recovery Community Organization
RCSP	Recovery Community Services Program
ROSC	Recovery Oriented Systems of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SOC	Standard Occupational Classification
SSA	Single State Authority

Appendix A: Benefits of Peer Recovery Support Services

Peer Recovery Support—It Works!

Addiction and Recovery

Over **20 million** Americans identify as in Recovery.

Yet only **10% of adults who need treatment for addictions actually get services.**

People need support to maintain abstinence and improve their lives before, during, and long after treatment.

RECOVERY LASTS A LIFETIME.

What are Peer Recovery Support Services?

PRSS are non-clinical, peer-run services that rebuild lives, reduce costs, and empower both peer leaders and people in new recovery.

[Peer leader training has] given us the opportunity to gain solid job skills and enhance a personal self-esteem that grows only when helping others.

—AIDS Service Center of New York City

RECOVERY/COACHING MENTORING

HEALTHY SOCIALIZING

PEER SUPPORT GROUPS

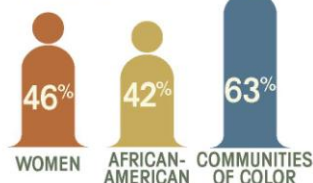HOUSING SUPPORT

EMPLOYMENT/ EDUCATION

The Value of PRSS

Reach vulnerable communities

Peer services extend the reach of treatment beyond the clinical setting into people's every day environments. In 2011, SAMHSA's PRSS programs served a diverse group of peers:

Sustain recovery, build community

In a group of over 1,000 people in recovery who received peer-led services:

PEERS

46% WOMEN

42% AFRICAN-AMERICAN

63% COMMUNITIES OF COLOR

28% Increase

Employment or enrollment in school

39% increase

Stable housing

Strong families

In Chicago, peer services reunited recovering parents with kids, saving the Department of Children and Families $5 million.

$5 million SAVINGS

The Value of PRSS (continued)

Build affordable, effective workforce

PRSS are anchored by rigorous peer training and codes of ethics. Peer specialists are often volunteers, making PRSS cost effective.

For the Connecticut Community for Addiction Recovery:

291 VOLUNTEERS + **23,264 HOURS** = **$646,041 IN-KIND**

PRSS Change Systems

Cut Costs

Peer programs cut costs and leverage partnerships across service systems.

22% SAVINGS

At Community Bridges, Inc. in Phoenix, peer specialists partnered with Fire and Police Departments to deliver peers from emergency settings to peer programs, **reducing the use of high cost crisis services by 22%**.

...peer-to-peer services have not only changed lives, but changed the way services are viewed, developed and delivered by multiple Arizona housing providers.
—Women in New Recovery, Mesa, Arizona

Services and activities need to be flexible...This means offering non-traditional service hours in non-traditional locations, sometimes using non-traditional methods.
—Center for Veterans Issues, Milwaukee, Wisconsin

Leverage Partnerships

Women in the San Diego County jail turn to Welcome Home Ministries (WHM) for peer services before and after release. **Seamless partnerships with the jail, courts, and treatment keep WHM's recidivism rate at 5%.**

5% RECIDIVISM RATE

Source: *Meeting Report: Perspectives on the Evolution and Future of PRSS*, SAMHSA/CSAT

Appendix B: *Meeting Agenda*

Consultation on the Evolution of Peer Recovery Support Services

September 11 – 12, 2012

Purpose: This consultation gathers lessons learned related to peer recovery support services. Participants will be former and current RCSP grantees from recovery community organizations (RCOs) and facilitating organizations (FOs), and other key informants working in State and other health systems. The focus of this meeting will be to gather information on quality program models for peer-based addictions recovery and how these approaches evolved through lessons learned from RCSP grantees, and to identify the tools and technical assistance that RCOs, FOs, and others may need to take PRSS into the post-ACA world.

Consultation Objectives:

Understand and document the achievements of the RCSP, and the challenges its grantees face looking ahead to the future.

Capture lessons learned related to PRSS (for recovery community organizations, facilitating organizations, States and localities, and health financing systems).

Gather ideas and strategies for PRSS in 2014 and beyond (our focus will be on possible TA products or tools and how the meeting summary can be used).

Day One	
Time	**Agenda Item**
9:00 – 9:15 AM	**Welcome from SAMHSA, Purpose**
9:15 –9:30 AM	**Overview of Objectives, Agenda**
9:30 – 10:15 AM	**Introductions**
10:15 – 10:30 AM	**BREAK**
10:30 – 11:30 AM	**PRESENTATION:** *The Legacy of RCSP and Advancing PRSS: Themes from Key Stakeholder Discussions*
11:30 – 12:15 PM	**GROUP DISCUSSION AND REFLECTIONS:** Group will provide reactions to the information presented on the themes from the discussions with key stakeholders: *Do these themes hit the mark?* *What stood out to you particularly?* *Are you left with other questions? What are those?* *What themes do you think are most important?* ***(We will gather the main themes around challenges to help form workgroups on day 2)***
12:15 – 1:15 PM	**LUNCH ON YOUR OWN**

Day One	
Time	**Agenda Item**
1:15 – 2:45 PM	<u>PRESENTATIONS:</u> PRSS from a Systems/Funders Perspective Discussants: Cassandra Price – State perspective, Georgia (10 min) Michael Botticelli – State perspective, Massachusetts (10 min) John Hogeboom – Managed care perspective, Arizona (10 Min) **<u>GROUP DISCUSSION:</u>** *What are the future challenges and opportunities for PRSS?* ***(We will gather the main themes around future challenges to help form workgroups on day 2)***
2:45 – 3:15 PM	BREAK
3:15 – 4:30 PM	<u>GROUP DISCUSSION:</u> Bringing it All Together Discussants: Maria Tarajano Rodman, Patty McCarty, Calvin Trent Reflect on key themes that have emerged and propose to the group the topics to address in small workgroups tomorrow. (**One group will specifically discuss TA ideas and strategies for RCOs, FOs and States)**
4:30 – 5:00 PM	CLOSE
Day Two	
Time	**Agenda Item**
9:00 – 9:20 AM	Recap of Day One
9:20 – 9:30 AM	Plan for Day 2, Introduce New People, Discuss Questions for SAMHSA
9:30 – 10:30 AM	Laying the Groundwork for Ideas and Strategies for PRSS in 2014 and Beyond: – Accreditation and credentialing – Peer roles and opportunities under ACA
10:30-10:45 AM	BREAK
10:45-12:00 PM	**<u>SMALL WORKGROUPS:</u>** Technical assistance ideas and strategies for RCOs, FOs and States TBD TBD
12:00 – 1:15 PM	LUNCH
1:15 – 2:00 PM 2:00 – 3:00 PM	<u>SMALL WORKGROUP PRESENTATIONS</u> (45 minutes) <u>DISCUSSION WITH PRINCIPAL DEPUTY ADMINISTRATOR Kana Enomoto</u>
3:00 – 4:00 PM	<u>FINAL GROUP DIALOGUE AND CLOSE:</u> Ideas and Strategies for PRSS in 2014 and Beyond

Appendix C: Participant List

Participant List

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